



14785 Preston Road, Suite 550 | Dallas, Texas 75254
Phone: 214 732 9359 | Fax: 972 980 7836

Notice of Independent Review Decision

DATE OF REVIEW: 8/17/2015

IRO CASE #

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Inpt LOS 3 days bilateral L4-S1 Anterior/ Posterior Fusion, Arthrodesis, Anterior Instrumentation.
63090.62

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D. Board Certified in Orthopedic Surgery and Spine Surgery.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Upheld | (Agree) |
| <input checked="" type="checkbox"/> Overturned | (Disagree) |
| <input type="checkbox"/> Partially Overturned | (Agree in part/Disagree in part) |

PATIENT CLINICAL HISTORY [SUMMARY]:

Patient is a female, status post lumbar laminectomies and discectomies all at L4-L5 (XXXXXX). She slipped and fell in xx/xx and now complains of moderate to severe low back and left leg pain. Her complaints, examination findings, spine MRI, and conservative care notes include medication management, physical therapy, and caudal ESI were reviewed.

ANALYSIS FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION AND EXPLANATION OF THE DECISION. INCLUDE CLINICAL BASIS.

Per ODG references, the requested "In pt LOS 3 days bilateral L4-S1 Anterior/ Posterior Fusion, Arthrodesis, Anterior Instrumentation" is medically necessary. The patient appeared to be fully functional prior to the fall in XXXX and her history, examination findings, and diagnostic findings are consistent with the pain generator emanating from the disc and lateral/foraminal stenosis supported by the MRI. She has mechanical low back pain radiating into the left leg. Treatment options including rest, activity modifications, medications, therapy and injections have all been tried for over XXXX XXXX with minimal relief. Her options include continued pain management versus surgery. is recommending a fusion at L4-L5 which he believes is her primary pain generator rather than a laminectomy given she has had three previous L4-L5 laminectomies. This recommendation is standard and meets ODG guidelines. Although results are variable with lumbar fusions in workers compensation patients, she appears to have done well with her laminectomy in XXXX and eventually returned to work. Xx is a smoker but smoking cessation has been discussed and studies support cessation postoperatively as is the plan with this case. Incorporating the L5-S1 into the fusion is standard within the spine community when fusing L4-L5 adjacent to a degenerating disc.



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**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR
OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES